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STD Testing and Treatment for Client and Partner Services

Learning Objectives

Participants will be able to recognize the importance of obtaining a Sexual Behavior Inventory to identify which STD testing is appropriate for their clients/patients.

Participants will recognize the importance of obtaining specimens from all areas that could harbor chlamydia and/or gonorrhea.

Significance of the STD Report Form, Partner Services-including EPT and follow-up STD testing.

Free Services

Rapid HIV

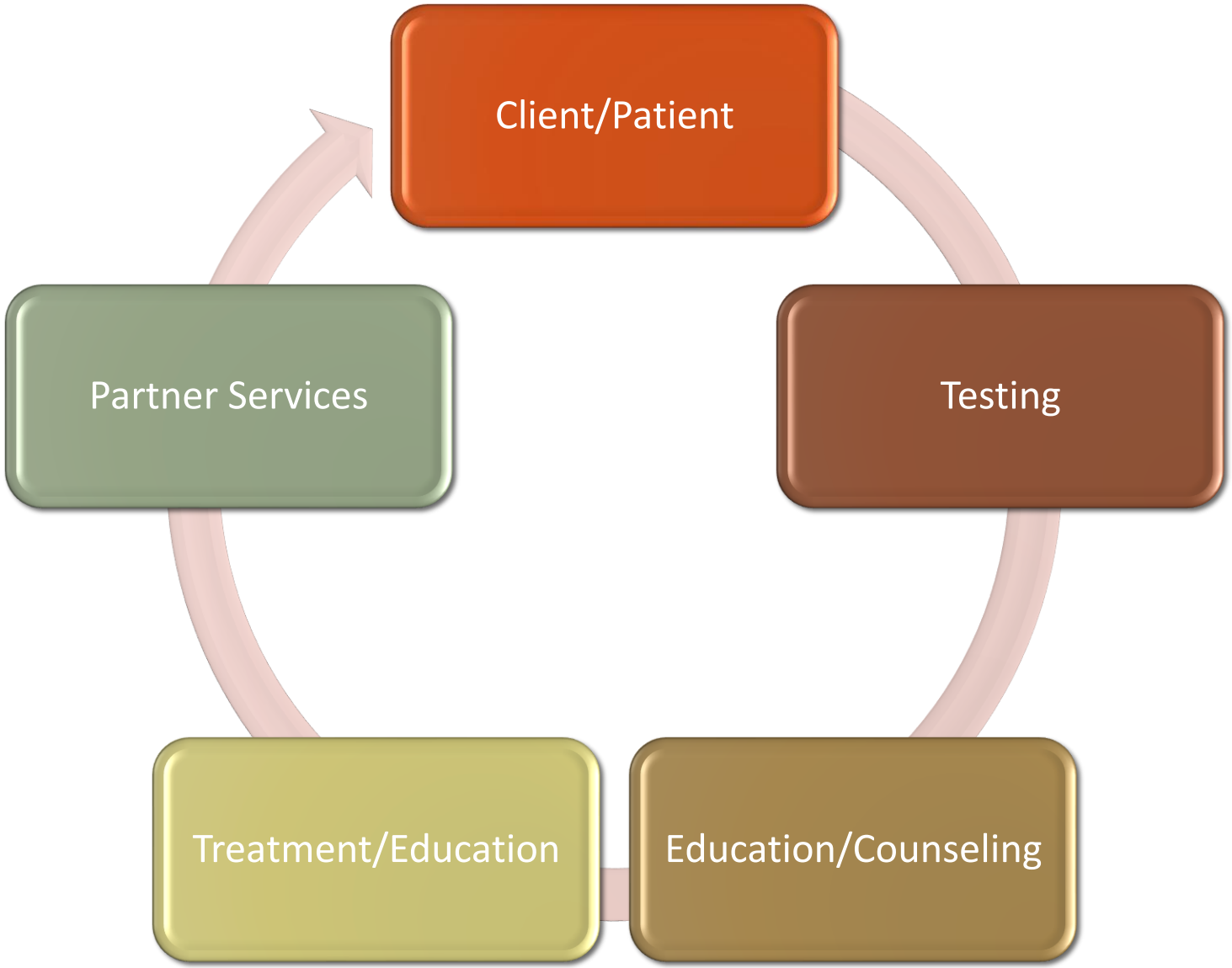
Rapid HCV

Testing/Treatment
Chlamydia

Testing/Treatment
Gonorrhea

Pregnancy test

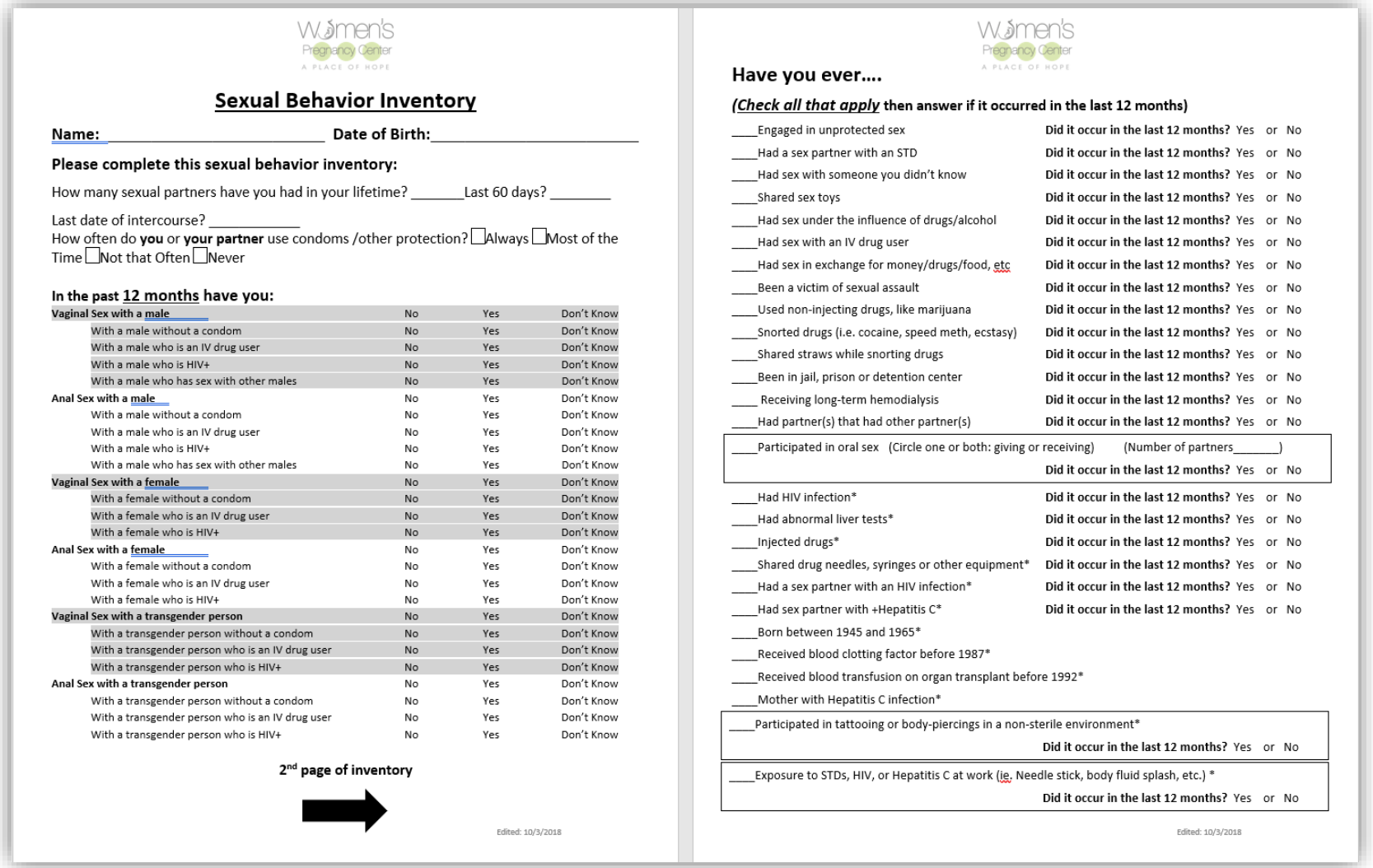
1st trimester limited U/S


Client/Patient
Testing
Education/Counseling
Treatment/Education
Partner Services

- Last Sexual Encounter
- Incubation period for Chlamydia (1 week)
- Incubation period for Gonorrhea (2-7 days)
- 9th day to test
- If symptoms-test asap
- Exposure to Chlamydia and/or Gonorrhea-test and treat asap

STD Appointment

Sexual Behavior Inventory



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Sexual Behavior Inventory

Name: _____ **Date of Birth:** _____

Please complete this sexual behavior inventory:

How many sexual partners have you had in your lifetime? _____Last 60 days? _____

Last date of intercourse? _____
How often do **you** or **your partner** use condoms /other protection? ☐Always ☐Most of the Time ☐Not that Often ☐Never

In the past 12 months have you:

Vaginal Sex with a male	No	Yes	Don't Know
With a male without a condom	No	Yes	Don't Know
With a male who is an IV drug user	No	Yes	Don't Know
With a male who is HIV+	No	Yes	Don't Know
With a male who has sex with other males	No	Yes	Don't Know
Anal Sex with a male	No	Yes	Don't Know
With a male without a condom	No	Yes	Don't Know
With a male who is an IV drug user	No	Yes	Don't Know
With a male who is HIV+	No	Yes	Don't Know
With a male who has sex with other males	No	Yes	Don't Know
Vaginal Sex with a female	No	Yes	Don't Know
With a female without a condom	No	Yes	Don't Know
With a female who is an IV drug user	No	Yes	Don't Know
With a female who is HIV+	No	Yes	Don't Know
Anal Sex with a female	No	Yes	Don't Know
With a female without a condom	No	Yes	Don't Know
With a female who is an IV drug user	No	Yes	Don't Know
With a female who is HIV+	No	Yes	Don't Know
Vaginal Sex with a transgender person	No	Yes	Don't Know
With a transgender person without a condom	No	Yes	Don't Know
With a transgender person who is an IV drug user	No	Yes	Don't Know
With a transgender person who is HIV+	No	Yes	Don't Know
Anal Sex with a transgender person	No	Yes	Don't Know
With a transgender person without a condom	No	Yes	Don't Know
With a transgender person who is an IV drug user	No	Yes	Don't Know
With a transgender person who is HIV+	No	Yes	Don't Know

2nd page of inventory

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Have you ever….

***(Check all that apply* then answer if it occurred in the last 12 months)**

____Engaged in unprotected sex **Did it occur in the last 12 months?** Yes or No
____Had a sex partner with an STD **Did it occur in the last 12 months?** Yes or No
____Had sex with someone you didn't know **Did it occur in the last 12 months?** Yes or No
____Shared sex toys **Did it occur in the last 12 months?** Yes or No
____Had sex under the influence of drugs/alcohol **Did it occur in the last 12 months?** Yes or No
____Had sex with an IV drug user **Did it occur in the last 12 months?** Yes or No
____Had sex in exchange for money/drugs/food, etc **Did it occur in the last 12 months?** Yes or No
____Been a victim of sexual assault **Did it occur in the last 12 months?** Yes or No
____Used non-injecting drugs, like marijuana **Did it occur in the last 12 months?** Yes or No
____Snorted drugs (i.e. cocaine, speed meth, ecstasy) **Did it occur in the last 12 months?** Yes or No
____Shared straws while snorting drugs **Did it occur in the last 12 months?** Yes or No
____Been in jail, prison or detention center **Did it occur in the last 12 months?** Yes or No
____ Receiving long-term hemodialysis **Did it occur in the last 12 months?** Yes or No
____Had partner(s) that had other partner(s) **Did it occur in the last 12 months?** Yes or No
____Participated in oral sex (Circle one or both: giving or receiving) (Number of partners_____) **Did it occur in the last 12 months?** Yes or No
____Had HIV infection* **Did it occur in the last 12 months?** Yes or No
____Had abnormal liver tests* **Did it occur in the last 12 months?** Yes or No
____Injected drugs* **Did it occur in the last 12 months?** Yes or No
____Shared drug needles, syringes or other equipment* **Did it occur in the last 12 months?** Yes or No
____Had a sex partner with an HIV infection* **Did it occur in the last 12 months?** Yes or No
____Had sex partner with +Hepatitis C* **Did it occur in the last 12 months?** Yes or No
____Born between 1945 and 1965*
____Received blood clotting factor before 1987*
____Received blood transfusion on organ transplant before 1992*
____Mother with Hepatitis C infection*
____Participated in tattooing or body-piercings in a non-sterile environment* **Did it occur in the last 12 months?** Yes or No
____Exposure to STDs, HIV, or Hepatitis C at work (ie. Needle stick, body fluid splash, etc.) * **Did it occur in the last 12 months?** Yes or No

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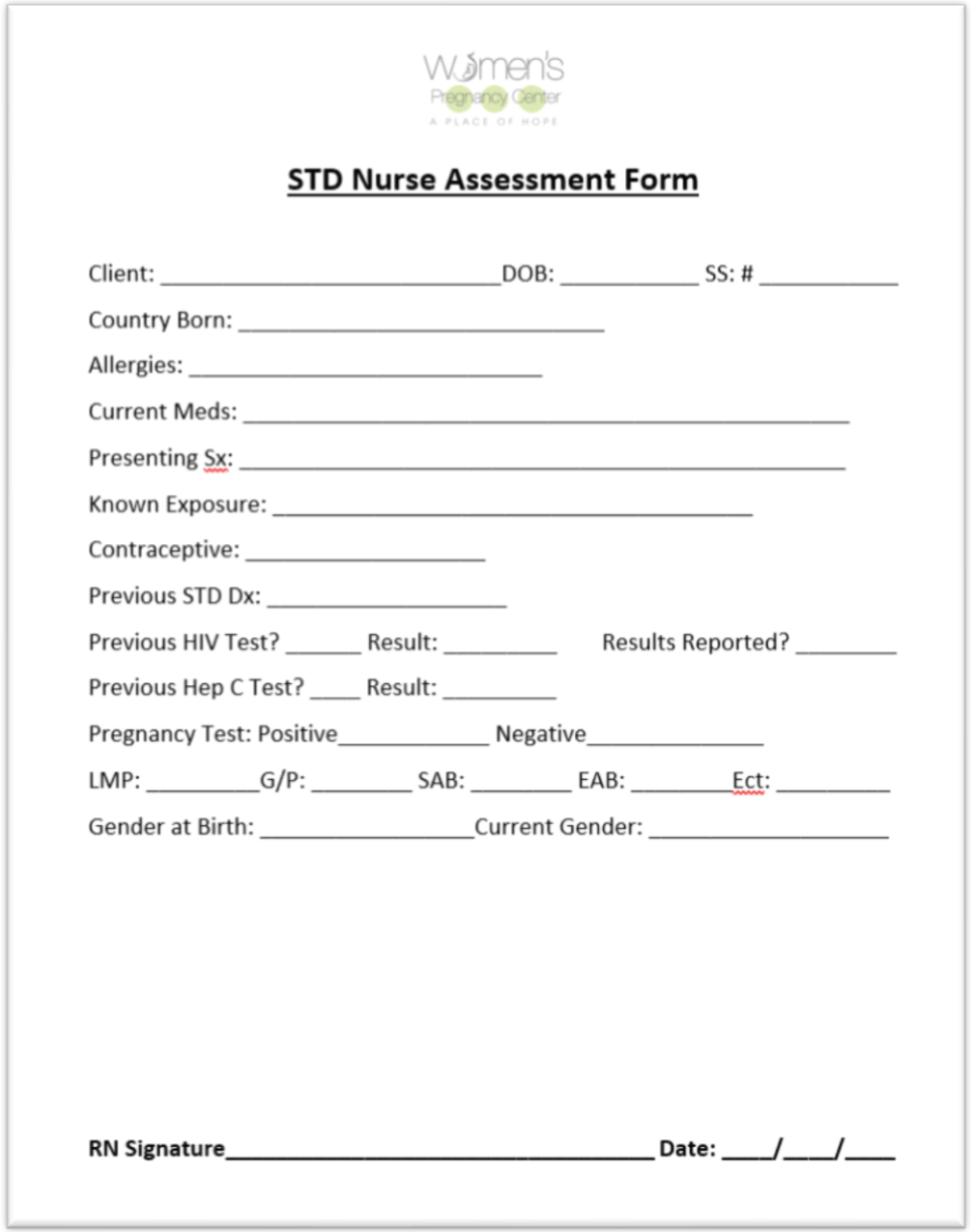
Assessment Form

- Allergies
- Symptoms
- Known Exposure
- Previous STD diagnosis
- Previous HIV or HCV testing/results



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STD Nurse Assessment Form

Client: _____DOB: _____ SS: # _____

Country Born: _____

Allergies: _____

Current Meds: _____

Presenting Sx: _____

Known Exposure: _____

Contraceptive: _____

Previous STD Dx: _____

Previous HIV Test? _____ Result: _____ Results Reported? _____

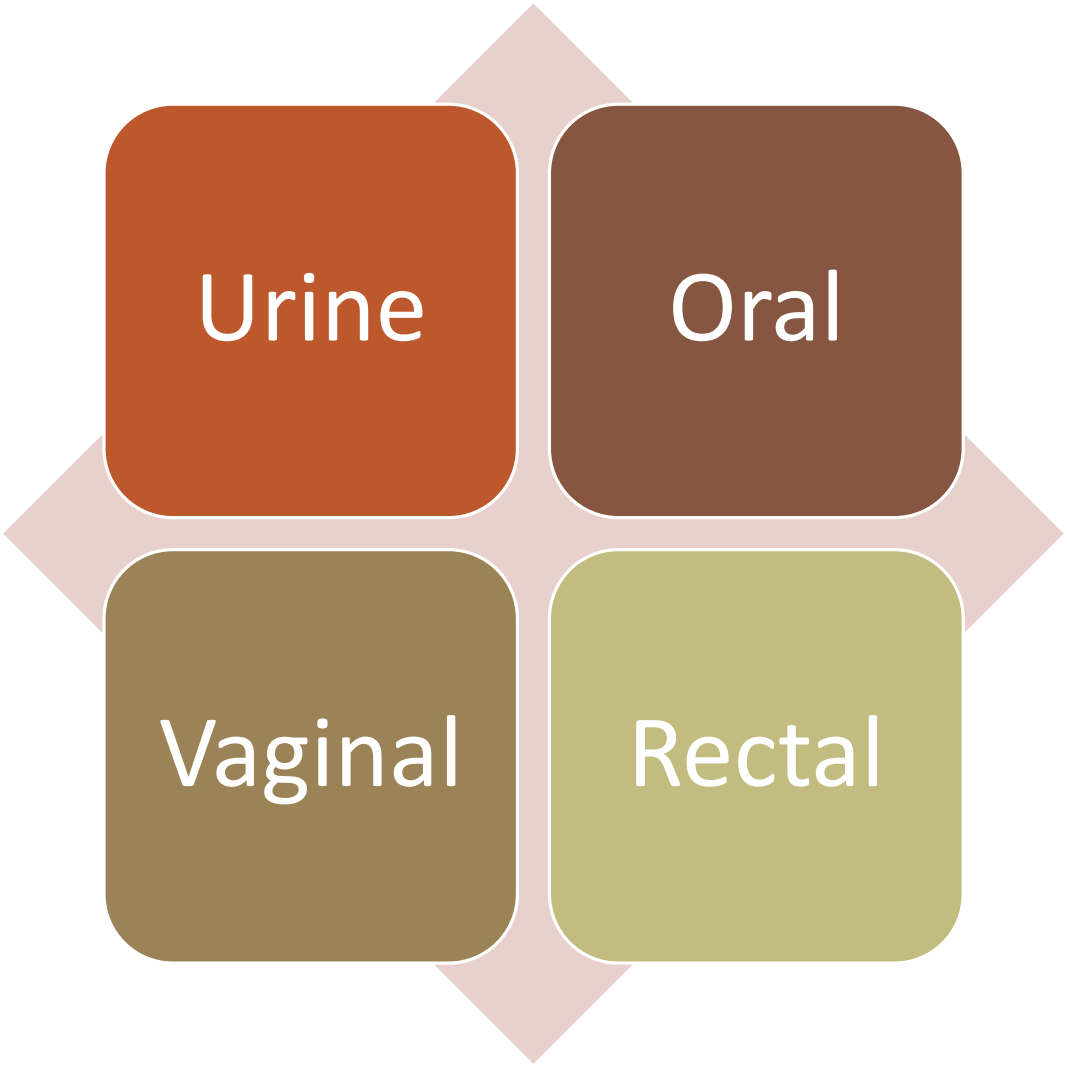
Previous Hep C Test? ____ Result: _____

Pregnancy Test: Positive_____ Negative_____

LMP: _____G/P: _____ SAB: _____ EAB: _____Ect: _____

Gender at Birth: _____Current Gender: _____

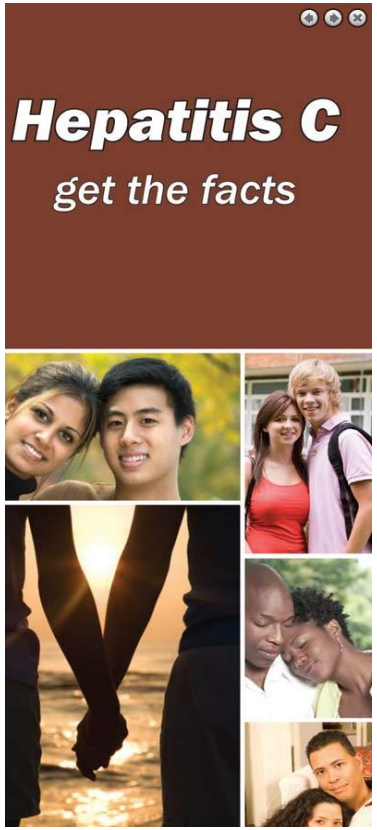
RN Signature_____ **Date:** ____/____/____

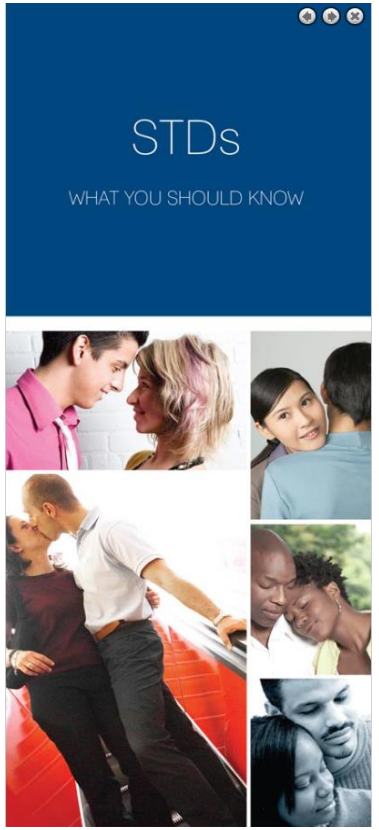


"IF YOU JUST CHECK THE PEE, YOU'LL MISS GC AND CT"

What should "Best Practice" for the Client look like?

Educate, Counsel





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_____, DOB: ____/____/____was tested for the following STD's on____/____/____

The results of these tests are listed below.

	Positive	Negative	Declined or N/A
Rapid HIV:	❑	❑	❑
Rapid HCV:	❑	❑	❑
Pregnancy:	❑	❑	❑

_____ _____ _____ _____
Client Signature Date Nurse Signature Date

	Positive	Negative	Declined or N/A
Urine			
Gonorrhea:	❑	❑	❑
Chlamydia:	❑	❑	❑
Oral			
Gonorrhea:	❑	❑	❑
Chlamydia:	❑	❑	❑
Vaginal			
Gonorrhea:	❑	❑	❑
Chlamydia:	❑	❑	❑
Rectal			
Gonorrhea:	❑	❑	❑
Chlamydia:	❑	❑	❑

_____ _____ _____ _____
Client Signature Date Nurse Signature Date

Any further sexual activity could make these results invalid.

Any further sexual activity with a non-exclusive partner or a partner with prior sexual exposure could make these results invalid. Exposure to an STD may occur, but depending on the infection, may not test positive in the body for weeks or even years. You were NOT tested for Hepatitis, HPV, Trichomoniasis, Herpes or Syphilis. If your nurse recommends further testing for these STD's, please notify your Primary Care Provider.

Specific HPV testing is not available for men. However, a visual exam by a physician can confirm genital warts caused by some strains of HPV, in either men or women. In women, an abnormal pap finding may suggest the presence of the HPV virus. Further testing may be suggested to determine the specific strain of HPV. This testing is necessary to determine if the type present is from the high risk viral subtypes which are a precursor to cervical cancer.

Testing for trichomoniasis in men is very difficult and limited. Women are tested through microscopic viewing, pap, and/or the rapid OSMO test. Men may be asymptomatic, but exposure to a positive result in a sexual partner must be treated. Therefore, all men with a known exposure to trichomoniasis are treated with medication presumptively.

PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT YOUR PARTNER(S)

1. **Current Partner**
   Name:_____Gender_____Race_____
   Age_____Date of Birth_____If partner is female, is she pregnant? Yes/No
   Address_____Phone_____Cell_____
   E-mail Address/Facebook Screen Name_____

   Name and relation (i.e. John Smith, dad) of person your partner lives with?
   _____
   DESCRIBE WHERE your partner lives:_____

   Name/Phone of place where your partner goes to work/school_____
   WHEN is the LAST time you had sex with this person?_____

   Please check one of the following:
   - ☐ My current partner is with me and is being treated now.
   - ☐ I will bring my current partner with me to the clinic to be treated.
   - ☐ I will contact my partner(s) directly and refer him/her to the clinic.

   Anything else you can think of to help locate, identify and contact this partner (nickname, piercings, tattoos, car)?_____

   For provider use only:
   TREATMENT OF PARTNER (include drug, dosage, duration, EPT)_____
   DATE OF TREATMENT_____

2. Partner's Name:_____Gender_____Race_____
   Age_____Date of Birth_____If partner is female, is she pregnant? Yes/No
   Address_____Phone_____Cell_____
   E-mail Address/Facebook Screen Name_____

   Name and relation (i.e. John Smith, dad) of person your partner lives with?
   _____
   DESCRIBE WHERE your partner lives:_____

   Name/Phone of place where your partner goes to work/school_____
   WHEN is the LAST time you had sex with this person?_____

   Please check one of the following:
   - ☐ I will contact my partner(s) directly and refer him/her to the clinic.
   - ☐ I prefer the clinic contact my partner directly and refer him/her to the clinic.

   Anything else you can think of to help locate, identify and contact this partner (nickname, piercings, tattoos, car)?_____

   For provider use only:
   TREATMENT OF PARTNER (include drug, dosage, duration, EPT)_____
   DATE OF TREATMENT_____

Completed by Provider:

Patient Name:	Date of Birth:
Laboratory: Collection Date:	Test Result:
Health Care Provider:	Facility:
Reason Test Conducted: ☐ Infection ☐ Screen	
Symptoms/Complications (i.e, PID, etc.):	Symptom Onset Date:
Pregnant? ☐ Yes ☐ No ☐ NA	If Yes, Due Date:
Treatment (drug, dosage, duration):	Treatment Date:
Was Treatment Delivered by Expedited Partner Therapy? ☐ Yes ☐ No	
Was Patient Tested for HIV at this visit? ☐ Yes ☐ No	Result: ☐ Positive ☐ Negative

PLEASE READ VERY CAREFULLY!

You are being tested and/or treated for a sexually transmitted disease (STD). It is very important for your health that your sexual partners are treated. Sex partners of persons infected with an STD may not know they are infected because many individuals do not have signs or symptoms of the infection or may only notice mild symptoms. It is very important that **ALL** of your current sex partners are treated in order to prevent you from becoming re-infected. Your name is strictly confidential and will not be used if the Department of Health refers partners to the clinic for medication.

Please list all the persons you have had sex with in the last **3 months**. If you have not had sex within this timeframe, list you last sex partner. Provide as much information as you can.

Note: It is important that you wait to have sex with anyone for at least 7 days after you have been treated and 7 days after you partner has been treated to avoid re-infection.

Your Information:

Home Phone #_____Cell Phone #_____Email:_____
Occupation_____Work Phone #_____
Address_____City_____State_____ZipCode_____
Gender_____Race_____Ethnicity (Circle): Hispanic or Not Hispanic

STD Risk Factors

1. Are you resident/staff of correctional facility?	☐ Yes ☐ No
2. Have you used intravenous/injection drugs?	☐ Yes ☐ No
3. Have you used non-injection drugs?	☐ Yes ☐ No
4. Have you had sex while high/intoxicated?	☐ Yes ☐ No
5. Have you had sex with an injection drug user?	☐ Yes ☐ No
6. Have you traded sex for drugs or money?	☐ Yes ☐ No
7. Have you had sex with an anonymous sex partner?	☐ Yes ☐ No
8. Have you ever met sexual partners on the internet?	☐ Yes ☐ No
9. Total number of sex partners in last 12 months	
a. Number of Female Partners	
b. Number of Male Partners	
10. How frequently does the patient use condoms during sex?	Always, Most of Time, Not that Often, Never

Please fax completed forms to NDDoH at 701.328.0324.

TREATMENT

CHLAMYDIA

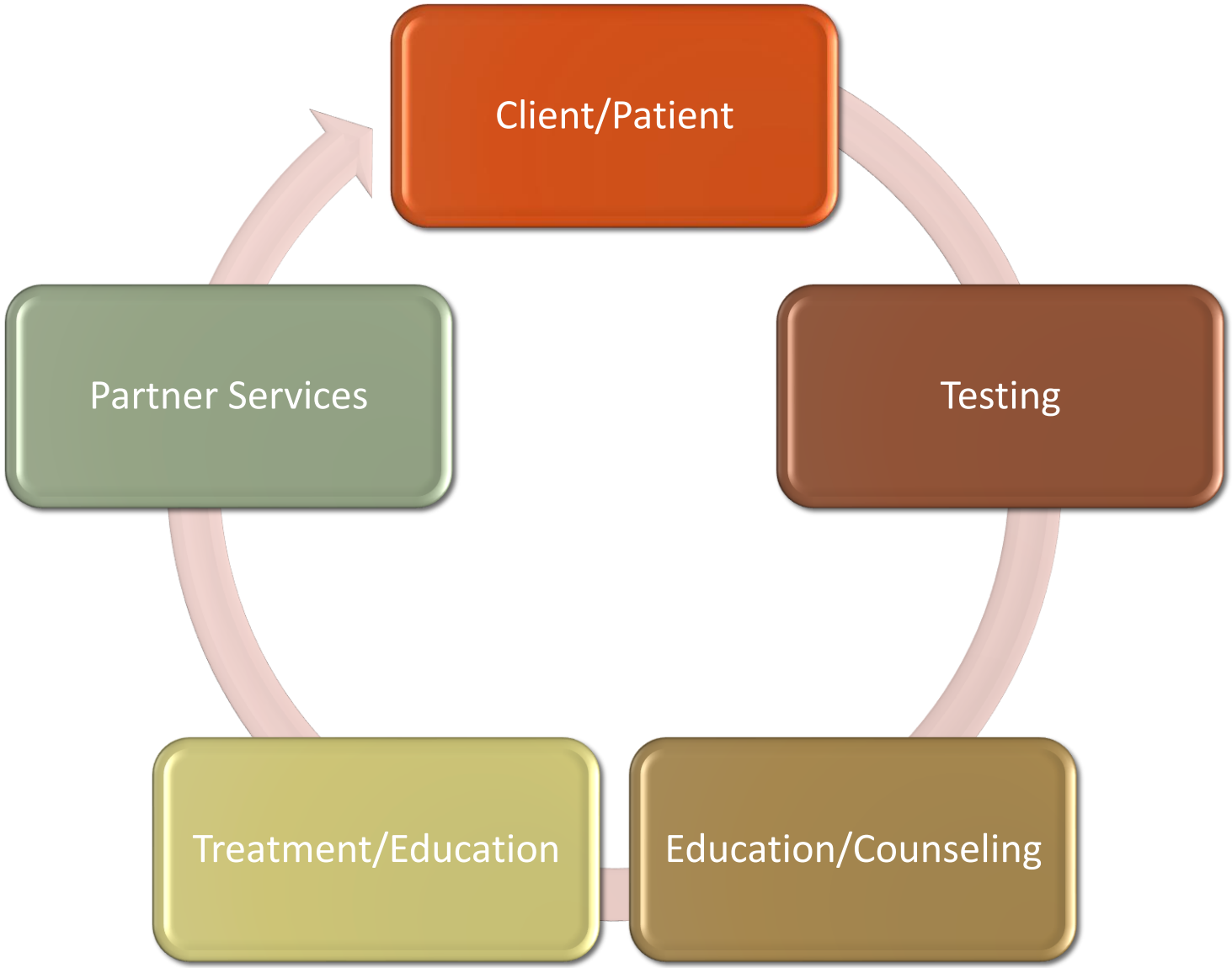
- 1 gm Azithromycin (orally)

GONORRHEA

- 1 gm Azithromycin (orally)
- 250 mg IM Ceftriaxone (Rocephin)

EXPEDITED PARTNER THERAPY (EPT)

RE-TEST 3 MONTHS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